DIRECT CARE

This section is for staff working directly with consumers. You may be:

- A case manager
- A nurse
- A community integration worker
- A clinical director
- An ACT team member
- Nurse practitioner or psychiatrist
- A direct support worker

No matter what your role is, you can play an important part in integrating health into the mental health setting. For many consumers, you are the trusted other. Consumers may be more comfortable with you and at your agency than they are at a primary care doctor's office.

> **"We've found that if we support our employee health and wellness, it creates a huge impact on employee attitude, which in turn supports the clients."**

FORM YOUR TEAM

Once you have decided that improving health and wellness within your agency is an important goal, form your team and give it a name. You can be the Health and Wellness team. Or the Integrated Care Leadership team. Giving your team a name will help pull people together and give them a sense of purpose and direction.

WHO IS ON THE TEAM?

Your team doesn't have to be as large as a football team. Five or six people can do great things!

It is important to have support from your administration in achieving your health and wellness goals. It is important to have consumers involved in your team. It is important to involve staff who works with consumers.

Teams in Maine that have done this work have had the following people on their teams:

- Consumers
- Case managers
- ACT team director
- Clinical director
- Psychiatric nurse practitioner
- Registered nurses
- Peer recovery center director
- Executive director

GETTING STARTED

Once you have your team formed, get together and brainstorm what it is you want to do about health and wellness goals. Come up with a vision. Set some goals. Start small.

Some examples of activities your teams could work on:

Educate staff about the health status of consumers and some of the health risks that they face.

> **Example:** Invite your medical director to talk about the rates of diabetes among people with SMI and the side effects of certain medications that cause weight gain and put people at higher risk for getting diabetes.

Start a health and wellness group for consumers.

> **Example:** Meet with a local diabetes educator and develop a series of classes for consumers about healthy eating, nutrition, and physical activity.

Identify local community resources that may help you achieve your health and wellness goals.

> **Example:** Find out where the closest Healthy Maine Partnership (HMP) is and what activities they offer. Most HMPs are eager to collaborate with mental health agencies in their service areas.

IMPLEMENTING A HEALTH SCREEN

When integrating health into mental health care, it is useful to have a concrete tool to assess consumers' health status and health risk behavior. Using a health screen can be a useful way to achieve this goal.

"Using the screen helped us to focus on consumers' health and to bring up sometimes difficult topics."

WHY HAVE A HEALTH SCREEN AT A MENTAL HEALTH AGENCY?

Having a health screen in place can make it easier for you to see where there are gaps in care for consumers. For example, if someone hasn't seen a primary care doctor in a year, it is a sign that they are not very well connected to their primary care doctor and may not be getting good preventive care. If they have diabetes, but haven't had a hemoglobin A1c test done at least twice a year, then consumers may not be getting quality care for their diabetes.

A health screen can also give you a way to bring up health topics with consumers or sensitive subjects like exercise or smoking and support them in taking positive steps toward improving their own health.

If health and wellness goals are documented in the Individual Support Plan (ISP) and in the case notes, MaineCare will reimburse for community support services that help the consumer reach health and wellness goals. One example: taking a consumer to a meeting with a diabetes educator and sitting in on the meeting with the consumer.

Consumers receiving certain atypical antipsychotic medications are at high risk of developing diabetes, so monitoring for weight gain or changes in glucose or lipid metabolism may guide changes in choice of medication.

> **"It's how you present it to people. If you present it as one more piece of paper, then consumers and staff won't buy in. The expectation should be full implementation."**

Many consumers rely on their mental health agency and trust the staff there. It is sometimes easier for you to work with consumers on health issues than it is for staff at a doctor's office. You may want to use the screen to work more closely with the primary care doctor providing care for the consumer you are working with. Examples: you could go with the consumer to primary care visits or coordinate with the care manager in the doctor's office.

The goal of the screen is not to replace primary care in the consumer's life, but to strengthen that relationship, to identify gaps, and to identify goals that the consumer may want to work on, like reducing smoking, exercising more or developing better diabetes self-management skills.

If consumers are not having their physical health needs met, Maine surveys show that they are also more likely to be unhappy with mental health services they receive and have poorer overall health and psychiatric functioning. Treating the health needs of people with SMI will also result in better mental health care.[8]

PUTTING THE PIECES TOGETHER

What elements do you want to include in a health screen?

There are several simple, measureable items, called direct measures, that are important to include in a health screen.

They are:

- Body Mass Index (BMI) from height and weight
- Blood pressure
- Results of lipid and glucose screens
- Medication lists

Doctors recommend that BMI be less than 25 and that blood pressure go no higher than 130/80.

DIABETES

Because so many people with SMI also have diabetes, the health screen examples in this toolkit include sections on quality care for diabetes. People who already have a diagnosis of diabetes should have the following checks done:

- Hemoglobin A1c test done at least **2 times per year** if the person is stable and **4 times per year** if the diabetes is not controlled
- Cholesterol testing at least **once a year**
- A foot exam **once a year**
- A dilated eye exam **once a year**

> **"The health screen helped remind everyone on the team that we were looking at the whole person."**

Given the high rates of prediabetes among people on antipsychotic medications, the following metabolic screenings are recommended by the American Diabetic Association and the American Psychiatric Association **when medications begin, after 12 weeks** and then **once a year:**

- BMI
- Blood pressure
- Fasting lipids
- Fasting glucose of hemoglobin A1c

HEALTH ASSESSMENT QUESTIONS INCLUDE:

It is fairly simple to get an idea of what health conditions consumers may have or what health risk behaviors they may want to work on simply by asking a question or having consumers complete a series of questions. This is called self-report.

Health Assessment Questions include:

- Have you ever been told that you have cardiovascular disease?
- Have you ever been told that you have high blood cholesterol?
- Have you ever been told that you have high blood pressure?

HEALTH RISK QUESTIONS:

- Do you smoke cigarettes?
- Do you exercise?
- For women, do you have two or more drinks per day?
- For men, do you have three or more drinks per day?

WHO SHOULD DO THE HEALTH SCREEN?

Through your team, you can work to see who in the agency is best suited to administer, or carry out, the screen. Some consumers can fill out a paper questionnaire with little or no staff support. If you have nurses on staff, they could work with consumers on the screen and calculate the BMI and blood pressure. If case managers are working with consumers on the screen, they can work with consumers answering the self-report questions and then work with nursing staff, medication management, or primary care to get information like blood pressure and lipid screens. Some mental health clinics may purchase blood pressure cuffs that work automatically and scales so that with appropriate training, even administrative support staff can measure blood pressure, or height and weight.

> **"One individual, once we started having discussions, became very motivated and started participating in all health and wellness activities. She lost 60 pounds in a year."**

ROLLING WITH RESISTANCE

Taking the health screen should be voluntary on the part of consumers. For consumers who wonder why, it may help to discuss with them how important their physical well-being is to their day-to-day functioning and recovery from their mental illness. If a consumer still doesn't want to work on the health screen, you could agree to put it aside and return to work on it another day. Sometimes just bringing up the topic is enough to get people thinking about their health and things they want to address. The next time you ask, you may be surprised at the answer. It also helps when health evaluations become a routine part of the initial evaluation and yearly update. The screen can then be understood as part of something the mental health center does to deliver high quality mental health care.

TWO HEALTH SCREEN EXAMPLES

The screens in this toolkit were both used by mental health agencies in Maine who were working on integrating health into their settings. One screen is shorter and more focused on certain key measures. One is longer and more comprehensive. The screen you pick depends on what your team has decided your goals are.

The first health screen was developed by the Maine Department of Health and Human Services' Office of Quality Improvement and Office of Adult Mental Health Services. The second screen was developed by Tri-County Mental Health Services. Both seek to assess health, see if a consumer is linked to primary care, and identify health risk behavior.

Health and Wellness Screen

Date of Screening _____

DIRECT MEASURES

Name _____ Age _____ Gender _____

Height _____ Weight _____ BMI _____

Blood Pressure _____ Lipid Screen ☐ Date _____

Obtained Medication List ☐ Yes ☐ No

Who is prescribing psychotropic medication? _____

DIABETES

Diabetes ☐ Yes ☐ No

A1c within the past year ☐ Yes ☐ No

A1c within the past 6 months ☐ Yes ☐ No

Dilated eye exam within past year ☐ Yes ☐ No

Foot exam within the past year ☐ Yes ☐ No

CONSUMER SELF REPORT

1. Have you ever been told by your doctor or other health professional that you have? (Check all that apply)
   - ☐ Angina or coronary heart disease
   - ☐ Heart attack or myocardial infarction
   - ☐ Stroke ☐ High blood cholesterol
   - ☐ High blood pressure or hypertension
2. Do you now smoke cigarettes? (Please check one)
   ☐ Every day ☐ Some days ☐ Not at all
3. During the past month, did you participate in any physical activities or exercises such as running, aerobics, basketball or other sports, gardening or walking for exercise? ☐ Yes ☐ No
4. On the days when you drink alcohol, about how many drinks do you drink on average? (One drink is one can or bottle of beer or wine cooler, one glass of wine, one cocktail or one shot of liquor.)
   Average number of drinks per day _____
5. How would you describe the condition of your teeth: (Please check one)
   ☐ Excellent ☐ Very good ☐ Good
   ☐ Fair ☐ Poor
6. How long has it been since you had your teeth cleaned by a dentist or dental hygienist?
   Number of months _____
   Number of years _____
7. How would you say your general health is? (Please check one)
   ☐ Excellent ☐ Very good ☐ Good
   ☐ Fair ☐ Poor
8. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
   Number of days _____
9. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
   Number of days _____
10. During the past 30 days, about how many days did poor physical or mental health keep you from doing usual activities, such as self-care, school, or recreation?
    Number of days _____

USUAL SOURCES OF CARE

Who is your primary care provider? _____

How often in the past 12 months have you seen your primary care provider? _____

How many times have you visited the Emergency Room in the last 12 months? _____

Tri-County Adult Mental & Physical Health Survey

Date of Screening _____

Name _____

Age _____ Gender ☐ Male ☐ Female ☐ Other

Height _____ Weight _____ BMI _____ Waist Circumference _____

Blood Pressure _____ Pulse _____ Recent Blood Sugar _____

1. Do you have a Primary Care Physician? (Check one):
   ☐ Yes ☐ No

   If you answered yes, please provide your doctor's name:

   _____

2. How many times a year do you see your Primary Care Physician? (Check one)
   ☐ None ☐ One ☐ Two ☐ Three ☐ Four or more

3. During the last month, how much have your personal or emotional problems interfered with your usual activities with friends, relatives, and neighbors? (Check one)
   ☐ Not at all ☐ Very little ☐ Somewhat
   ☐ Quite a lot ☐ All the time

4. During the last month, how often did you feel nervous or anxious? (Check one)
   ☐ Not at all ☐ Very little ☐ Somewhat
   ☐ Quite a lot ☐ All the time

5. During the last month, how often did you feel fearful or worried? (Check one)
   ☐ Not at all ☐ Very little ☐ Somewhat
   ☐ Quite a lot ☐ All the time

6. During the last month, how often did you feel stressed or overwhelmed? (Check one)
   ☐ Not at all ☐ Very little ☐ Somewhat
   ☐ Quite a lot ☐ All the time

7. During the last month, how often did you feel depressed or sad? (Check one)
   ☐ Not at all ☐ Very little ☐ Somewhat
   ☐ Quite a lot ☐ All the time

8. During the last month, how would you rate your sleep quality overall? (Check one)
   ☐ Very bad ☐ Fairly bad ☐ Average
   ☐ Fairly good ☐ Very good

9. During the last month, how was your appetite? (Check one)
   ☐ Very bad ☐ Fairly bad ☐ Average
   ☐ Fairly good ☐ Very good

10. Do you smoke cigarettes? (Check one) ☐ Yes ☐ No

11. Thinking of an average day this past month, how many servings of alcohol did you have in a typical day? One serving is a can of beer, glass of wine, or a shot of hard liquor. (Check one)
    ☐ None ☐ 1-2 servings ☐ 3-4 servings
    ☐ 5-6 servings ☐ 7 or more servings

12. In general, how is your overall physical health? (Check one)
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

13. Compared to one year ago, how would you rate your health in general? (Check one)
    ☐ Much better now than a year ago
    ☐ Somewhat better now than a year ago
    ☐ About the same as one year ago
    ☐ Somewhat worse now than one year ago
    ☐ Much worse now than one year ago

14. During the last month, how has your physical health interfered with your usual activities, like visiting friends/relatives, walking, climbing stairs, cleaning? (Check one)
    ☐ Not at all ☐ Very little ☐ Somewhat
    ☐ Quite a lot ☐ All the time

15. During the last month, how often did you lift or carry your own groceries? (Check one)
    ☐ Not at all ☐ Very little ☐ Somewhat
    ☐ Quite a lot ☐ All the time

16. During the last month, how often did you climb flights of stairs? (Check one)
    ☐ Not at all ☐ Very little ☐ Somewhat
    ☐ Quite a lot ☐ All the time

Tri-County Adult Mental & Physical Health Survey

17. During the last month, how often did you have difficulty bending or kneeling? (Check one)
☐ Not at all ☐ Very little ☐ Somewhat
☐ Quite a lot ☐ All the time

18. During the last month, how often did you have difficulty walking from place to place? (Check one)
☐ Not at all ☐ Very little ☐ Somewhat
☐ Quite a lot ☐ All the time

19. Within the last month, have you experienced any of the following? (Check all that apply)
☐ Frequent urination ☐ Excessive thirst
☐ Extreme hunger ☐ Unusual weight loss
☐ Increased fatigue ☐ Irritability
☐ Blurry vision

20. Do you have family members with diabetes? (Check one): ☐ Yes ☐ No

21. Have you recently had labs (blood work) done? (Check one) ☐ Yes ☐ No

22. Do you currently take any of the following medication listed? (Check all that apply)
☐ Clozapine/Clozaril ☐ Olanzapine/Zyprexa
☐ Quetiapine/Seroquel ☐ Asenapine/Saphris
☐ Risperidone/Risperdal ☐ Sulpiride/Meresa
☐ Amisulpride/Solian ☐ Remoxipride
☐ Aripiprazole/Abilify ☐ Perospirone/Lullan
☐ Melperonel/Buronil ☐ LLoperidone/Fanapt
☐ Paliperidone/Invega ☐ Sertindole/Serdolect
☐ Ziprasidone/Geodon

23. Have you ever been told by your medical doctor or any other medical professional that you have any of the following? (Check all that apply)
☐ Heart Disease ☐ Heart Attack
☐ Stroke ☐ High Blood Pressure
☐ High Cholesterol ☐ Diabetes
☐ Asthma ☐ Arthritis
☐ Epilepsy ☐ Seizures
☐ Liver Disease ☐ Overweight
☐ HIV ☐ Underweight

If you **checked Diabetes** in question 23, please answer the following questions. If you **did not check Diabetes,** you are done with the survey.

24. How many times a year do you see a doctor for your Diabetes? (Check one)
☐ None ☐ One ☐ Two ☐ Three ☐ Four or more

25. Do you know what your last A1c level was? A1c level is blood work completed at a lab that provides information about your average glucose level over a three-month period. (Check one) ☐ Yes ☐ No

If you answered yes, what was your level: _____

26. If you are taking any medications listed in question 22, have you had a recent lipid done? ☐ Yes ☐ No

27. How many times throughout the day do you check your glucose level using your portable monitor? (Check one)
☐ None ☐ One ☐ Two ☐ Three ☐ Four or more

28. When was your last foot exam? (Check one)
☐ Never ☐ Within 3 months ☐ Within 6 months
☐ Within 12 months ☐ 12 months plus

29. When was your last eye exam? (Check one)
☐ Never ☐ Within 3 months ☐ Within 6 months
☐ Within 12 months ☐ 12 months plus

Please see Appendix 1 for a list of the sources Tri-County Mental Health Services consulted with in preparing this screen.

A THIRD HEALTH SCREEN OPTION: KEEPMEWELL

The Maine Center for Disease Control and Prevention developed the online **KeepMEWell** health assessment tool. The **KeepMEWell** screen is designed to help Maine residents assess their risk for chronic disease, improve their health through education, and link them to local resources and supports that can help them decrease their risk of chronic disease. You can access the screen at: **www.keepmewell.org.**

The screen is for people 18 and older.

WHAT DOES THE SCREEN DO?

After answering a series of health questions, you will get three reports:

1. **A scorecard:** a summary of your risk for chronic disease
2. **My Report:** feedback and links to trusted health information websites that will help you take action to lower your risk for chronic disease
3. **Local Community Supports and Programs:** Based on the results of the assessment, you will receive a customized report from **KeepMEWell** listing local resources that can help you take action with health risks that are identified

Within your agency, you could use **KeepMEWell** in several ways:

- Have staff work on the screen with consumers
- Print out the reports and incorporate some of the goals into the Individual Support Plan (ISP)
- Distribute free information about **KeepMEWell** (available from the Maine CDC) and encourage consumers to do the screen at home
- Have the screen be a topic at a social club event
- Have the screen be a topic at a health and wellness group for consumers

WHAT NEXT?

Once you have selected a health screen, or developed one of your own based on components of these examples, it is a good idea to identify a sub group, or target population, of people within your agency to test the screen on.

Agencies that have done this work in Maine have first tested the screen on the following target populations:

- ACT teams
- People in residential settings
- Clients of case managers
- Clients of medication management unit
- Clubhouse members

PLAN-DO-STUDY-ACT

After you have picked the group of people you want to screen and identified the staff you want to do it, it is useful to have a tool to see how that change worked or didn't work. We can borrow a work sheet often used in health care settings called the Plan-Do-Study-Act Worksheet for Testing Change developed by the Institute for Health Care Improvement. (Please see worksheet on the next page).

THE LESSON OF LOW LYING FRUIT

Feeling good about early accomplishments and victories is very important. Even after staff education and consumer education, any change in workflow or in practice can feel quite overwhelming. By testing your screen first on a small defined population, and using the Plan-Do-Study-Act worksheet, you can best test change and learn from it without becoming overwhelmed by it.

The Plan-Do-Study-Act tool helps teams to be clear on their goals, to test change, and to learn from it.

The Plan-Do-Study-Act (PDSA) Worksheet is a useful tool for documenting a test of change. The **PDSA cycle** is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Teams can then spread the new practice use of the change, such as the health screen, to broader populations. For example, an agency that started with its ACT team members may want to then more on using the screen on all Community Integration clients. The Plan-Do-Study-Act worksheet is useful in helping your team test out the use of a health screen. Or any other health and wellness change you may want to test at your agency.

PLAN DO STUDY ACT WORKSHEET

AIM – Overall goal you wish to achieve *Every goal will require multiple smaller tests of change*			
Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**
PLAN			
List the tasks needed to set up this test of change:	**Person responsible**	**When to be done**	**Where to be done**
Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**		
DO			
Describe what actually happened when you ran the test			
STUDY			
Describe the measured results and how they compared to the predictions			
ACT			
Describe what modifications to the plan will be made for the next cycle from what you learned			

Source: Plan Do Study Act Worksheet for Testing Change, Institute for Health Care Improvement

REGISTRY

Once you have used the health screen for your target population, you will have a series of completed individual screens. It is useful to take this individual information and gather it together into a whole or aggregate. This is called a registry. By doing this, you can see how the people you serve are doing as a group. You can use this information to make decisions about interventions you may want to try. For example, if you see that many consumers at your agency are smoking, you may want to contact your local HMP and find out about smoking cessation programs in your area.

The registry template on the next page is based on the Maine Department of Health and Human Services' screen. It is created by using a simple Excel program. You can set a date each month to enter data. This can also be useful to keep your project on track. If you have a month where no one has been screened, you may want to investigate why.

INCENTIVES

We all respond to rewards. We all know that resources are tight in these hard fiscal times. But if funds can be identified to buy gym memberships, aerobic water classes, and food portion kits, these can be useful in creating excitement and buy-in for the wellness measures as well as institutionalizing wellness measures.

Make it fun. Provide healthy snacks at a wellness group meeting. Celebrate successes no matter how small. Consumers who have participated in health and wellness efforts have also said they felt empowered when getting positive reinforcement from their primary care doctor for better managing their blood sugar. Consumers who participated in diabetes support group sessions received a Hannaford gift card at the conclusion of the groups. Consumers who attended the Living Well training on how to better manage their chronic diseases said they felt great when they developed an Action Plan to address a health condition that they had been meaning to work on.

Integrating Health into Mental Health Systems of Care

Health Screen Registry Template

Date:

Pilot site:

Program:

Number in target program:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
DIRECT MEASURES													
Number of people screened													
Number of BMIs > 25													
Blood pressure: Number of people with BP > 130/80													
Lipid: Number of lipid screens													
Med lists: Number of medication lists obtained													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
CONSUMER SELF REPORT													
Number of people who have been told that they have cardiovascular disease (angina or coronary heart disease, heart attack or myocardial infarction, stroke)													
Number of people who have been told they have high blood cholesterol													
Report on the number of people who have been told that they have high blood pressure													
Number of people who smoke cigarettes													
Number of people who participate in any physical activities or exercise													
Number of women who have two or more drinks per day													
Number of men who have three or more drinks per day													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
DIABETES													
Number of people who have been told that they have diabetes													
Number of people with diabetes who have had A1cs done within the past year													
Number of people with diabetes who have had A1cs done within the past 6 months													
Number of people with diabetes who have had foot exams within the past year													
Number of people who have had dilated eye exams within the past year													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
USUAL SOURCES OF CARE													
Number of people who have primary care provider													
Number of people who have seen PCP in the past 12 months													
Number of people who have visited the ER in the past 12 months													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
OUTCOMES													
Number of people who said that within the last 30 days, poor physical or mental health kept them from doing usual activities such as self-care, school, or recreation for >14 days													